Case Number:	CM14-0155630		
Date Assigned:	09/25/2014	**Date of Injury:**	10/15/2013
Decision Date:	11/19/2014	**UR Denial Date:**	09/12/2014
Priority:	Standard	**Application Received:**	09/23/2014

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The applicant is a represented [redacted] employee who has filed a claim for left knee pain and deep venous thrombosis of the left lower extremity reportedly associated with an industrial injury of October 15, 2013.Thus far, the applicant has been treated with the following: Analgesic medications; transfer of care to and from various providers in various specialties; and lower extremity venous duplex ultrasound of August 13, 2014, notable for DVT of the left popliteal, age unknown.In September 12, 2014 Utilization Review Report, the claims administrator retrospectively denied a three-day stay for ventilation perfusion scan. The claims administrator stated that the applicant had had a left lower extremity venous duplex ultrasound of August 13, 2014, which documented a DVT of the left popliteal vein. The V/Q scan was apparently performed on September 2, 2014 and was reportedly negative for pulmonary embolism, the claims administrator went on to note.The applicant's attorney appealed the denial.In a July 17, 2014 progress note, the applicant reported ongoing complaints of left lower extremity pain. Positive McMurray's test was noted. Left knee arthroscopy was sought. Norco and Naprosyn were prescribed. The attending provider sought authorization for left lower extremity venous Doppler to rule out any underlying DVT to explain the applicant's chronic left leg swelling. Work restrictions were endorsed.The claims administrator stated that it was basing its decision, in part, on a September 2, 2014 progress note.In a handwritten progress note dated September 2, 2014, the applicant was described as having a DVT of the left lower leg. The applicant was reportedly admitted to telemetry. It was stated that the applicant had undergone a ventilation perfusion scan, which demonstrated a low probability for pulmonary embolus. The applicant was reportedly using Lovenox and Norco.In a handwritten telemetry note of September 1, 2014, the applicant was described as using oral Coumadin.

IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

Retrospective inpatient stay for ventilation perfusion scan: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation wensite www.ncbi.nih.gov/pubmed/23412596

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: 1. Outpatient vs. Inpatient Management of Acute DVT Am Fam Physician. 2002 Dec 15;66(12):2321-2322. The authors conclude that the treatment of acute proximal DVT with LMW heparin in a primary outpatient setting is safe and effective. In addition, the use of this type of heparin can lead to reduction in cost of treatment by eliminating or reducing the number of inpatient stays. KARL E. MILLER, M.D. Spy

Decision rationale: The MTUS does not address the topic. Based on the documentation reviewed, it appears that the applicant was admitted to telemetry for initial anticoagulation for the DVT and also for performance of the ventilation perfusion scan. As noted in American Family Physician, however, an acute proximal DVT can be treated in an outpatient setting with a low molecular weight heparin and can successfully reduce the cost of treatment by eliminating or reducing the number of inpatients stays. In this case, it was not clearly stated why the applicant's uncomplicated DVT required an inpatient stay of three days, as apparently transpired here. Similarly, while the Society for Nuclear Medicine (SNM) also notes that ventilation-perfusion scanning/lung scintography can be employed to assess pulmonary perfusion and to determine the presence or absence of pulmonary embolism, SNM qualifies its position by noting that a chest x-ray should be performed a V/Q scan is preformed. In this case, a pre-procedure chest x-ray was not seemingly performed or documented. It is further noted that the applicant's presentation was not necessarily suggestive of pulmonary embolism. There was no mention of issues with chest pain, dyspnea, etc., reported in the attending provider's handwritten progress notes. It was not clearly stated why a V/Q scan was being performed when the applicant's presentation was consistent with that of a simple uncomplicated DVT. Finally, the V/Q scan was apparently preformed and demonstrated low probability for pulmonary embolism. It was not clear why the attending provider went on to keep the applicant in the hospital for three days for anticoagulation purposes after the negative V/Q result was obtained. For all of the stated reasons, then, the request was not medically necessary.